

2339

CERTIFICATE OF DEATH

Reg. Dist. No.

02312

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Navy Point</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H. T.</u> Last <u>Colbourne</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/67</u>	9. AGE (In years last birthday) <u>91</u> yrs.	10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel E. Colbourne</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>24-30-7882 A</u>			
				17. INFORMANT Address <u>Miss Mary J. Colbourne, St. Michaels</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial failure</u> DUE TO (c) <u>atherosclerotic coronary heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead 3 AM 2-8-59</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5-11-1954</u> to <u>2-8-1959</u> , that I last saw the deceased alive on <u>2-1-1959</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thy M. Reeser</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Michaels Md</u>			
PHYSICIAN'S NAME (Type) <u>Thy M. Reeser</u>				DATE SIGNED <u>2-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dechell</u> ADDRESS <u>Boston, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. BROWN		45		M		W		JAN 15 1900		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
123 MAIN ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		1234		JAN 16 1900	
BORN		DIED		AGE		SEX		RACE		PLACE OF BIRTH	
JAN 1 1855		JAN 15 1900		45		M		W		MASSACHUSETTS	
FATHER		MOTHER		SPOUSE		CHILDREN		BROTHERS		SISTERS	
JAMES BROWN		MARY BROWN		ELIZABETH BROWN		JOHN BROWN		WILLIAM BROWN		ANNE BROWN	
EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		MARITAL STATUS		PREVIOUS MARRIAGES	
HIGH SCHOOL		METHODIST		REPUBLICAN		NONE		MARRIED		NONE	
SIGNED BY		DATE		PLACE		OFFICE		STATE		COUNTY	
J. H. BROWN		JAN 16 1900		BOSTON		HEALTH DEPT.		MASS.		SUFFOLK	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G238 2-13-59 et

2323

CERTIFICATE OF DEATH

Reg. Dist. No.

02313

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN <u>1 wk</u>				d. STREET ADDRESS <u>1524 Goldsboro St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>Virginia</u> Last <u>DAVIDSON</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 17 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Penna.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Leonard Swartz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Writte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>W. C. Davidson</u> Address <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>neurosis left ventricle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old myocardial infarct</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>Feb 19 1959</u> and that death occurred at <u>1:15</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u> DATE SIGNED <u>Feb 59</u>							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 7, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Newnam, Sr.</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb 10 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2324

CERTIFICATE OF DEATH

Reg. Dist. No.

02314

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>H.</u> Last <u>Eason</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/77</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel A. Eason</u>				14. MOTHER'S MAIDEN NAME <u>Laura Quimby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0 due to Acute hemorrhagic Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pancreatitis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 1, 1959</u> to <u>February 1, 1959</u> , that I last saw the deceased alive on <u>February 1, 1959</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Westington St. Easton 16, Maryland</u>			
DATE SIGNED <u>2 Feb 59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neenan & Son</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner	
Signature of County Health Officer		Signature of State Health Officer		Signature of State Registrar		Signature of State Coroner		Signature of State Medical Examiner	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2325

CERTIFICATE OF DEATH

Reg. Dist. No.

02315

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>R7D #1</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Edward S. EVANS</u>		4. DATE OF DEATH <u>Feb 24 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Thomas EVANS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Elizabeth Clark</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastric ulcer</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>59</u> , to <u>2-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>59</u> , and that death occurred at <u>11:50</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u>		ADDRESS <u>Denton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2326

CERTIFICATE OF DEATH

02316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>107 Blake street</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Grant</u> Last <u>Grant</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>7</u> - Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/96</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto repair</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Abraham Grant</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Apple Gait</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>155-09-524</u>		17. INFORMANT <u>Mrs. Harry Grant</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				
21. I certify that I attended the deceased from <u>JAN 7</u> , 19 <u>59</u> , to <u>2/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>59</u> , and that death occurred at <u>3:24</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>2/9/59</u>							
ACTUAL SIGNATURE <u>L. J. Egleader</u> M.D. <u>Easton, Md.</u>				PHYSICIAN'S NAME (Type) <u>L. J. Egleader</u> <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall E. Newnam</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2328

CERTIFICATE OF DEATH

Reg. Dist. No.

2319

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>4 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Michaels</u>	
f. STREET ADDRESS <u>1</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Giles</u> Middle <u>Hicks</u> Last <u>Jump</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1959</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Jump</u>	
14. MOTHER'S MAIDEN NAME <u>MARTHA MARSHALL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>11-4-100000</u>		17. INFORMANT <u>Dr. J. H. Marshall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>No</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>00</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 7, 1959</u> to <u>Feb 11, 1959</u> , that I last saw the deceased alive on <u>Feb 7, 1959</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>1001 St. Michaels Rd.</u>		DATE SIGNED <u>Feb 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. H. Marshall</u>		M.D. <u>St. Michaels, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>		ADDRESS <u>St. Michaels</u>	
24a. REC'D BY REGISTRAR <u>Feb 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2329

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>			
				f. STREET ADDRESS <u>1</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Alvin LOMAX</u>				4. DATE OF DEATH Month Day Year <u>February 13 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Subcarrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Mr. Silas W. LOMAX</u>				14. MOTHER'S MAIDEN NAME <u>Jane Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Charm Lomax</u>				Address <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>							
DUE TO <u>Surgery</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Ruptured appendicitis</u>							
DUE TO (c) <u>2/1/59</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/2/59</u> to <u>2/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>59</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. T. B. Ambler</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>J. T. B. AMBLER</u>				DATE SIGNED <u>EASTON, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. A. Harrison</u>				ADDRESS <u>St. Michaels Md</u>		24a. REC'D BY REGISTRAR <u>Feb 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. S. Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2330

CERTIFICATE OF DEATH

2321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 2 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELWOOD First NELSON Middle MARSHALL Last				4. DATE OF DEATH FEBRUARY 11 1959 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895 November 17, 1895	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK ROOM CLERK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK				14. MOTHER'S MAIDEN NAME NETTIE BURROWS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-10-6562		17. INFORMANT Wife Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) atherosclerotic cardiovascular d. DUE TO (c) Diabetes mellitus, peripheral vascular occlusive d.							INTERVAL BETWEEN ONSET AND DEATH 1 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 1954 to 2-11-1959 , that I last saw the deceased alive on 2-11-1959 , and that death occurred at 3 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thy M. Beeser M.D.				ADDRESS (Street, city or town, state) St. Michaels Md DATE SIGNED 2-11-59			
PHYSICIAN'S NAME (Type) Thy M. Beeser							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-59		22c. NAME OF CEMETERY OR CREMATORY Clint Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Hamilton Harrison ADDRESS St. Michaels Md.				24a. REC'D BY REGISTRAR FEB 16 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

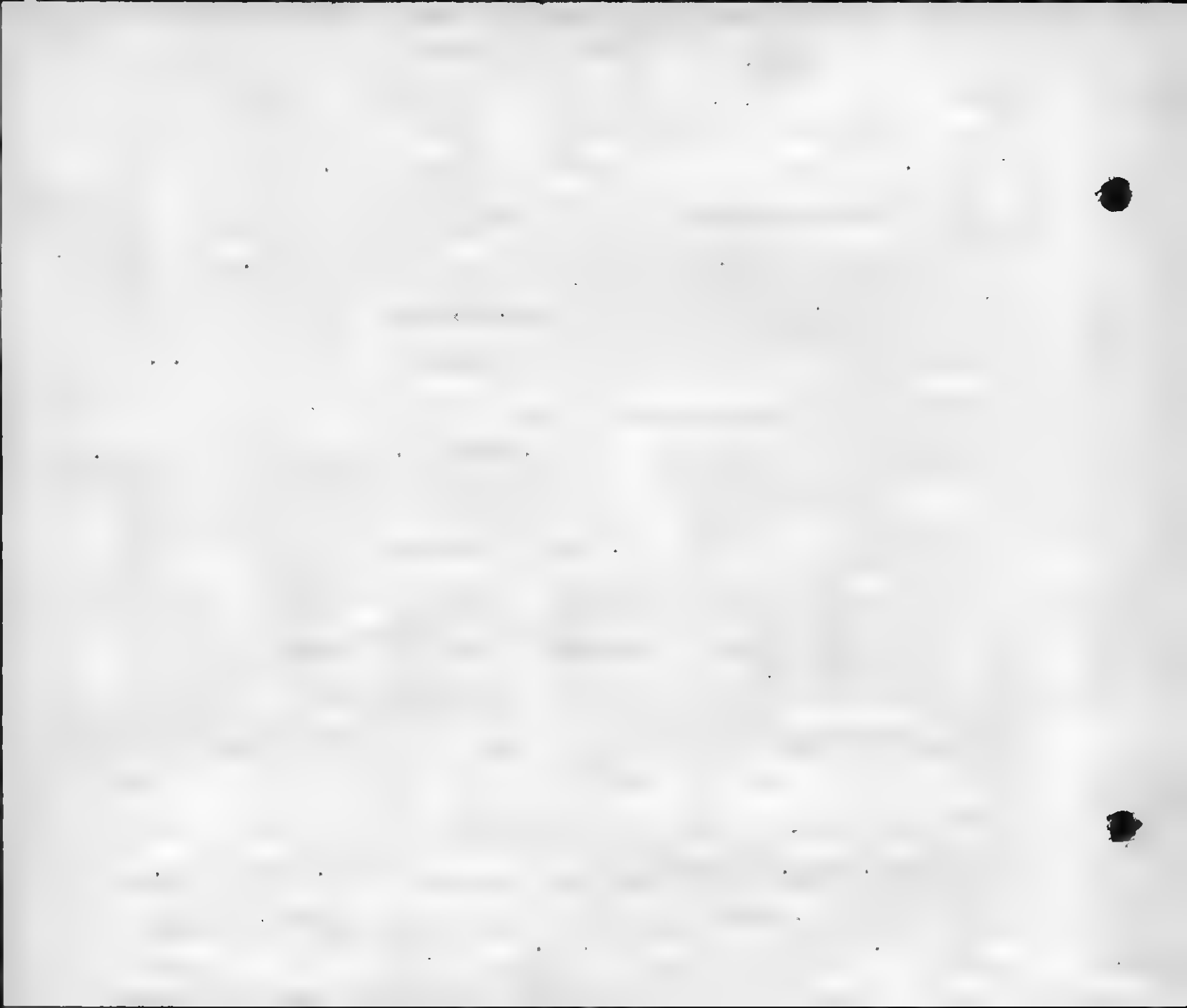
2340

CERTIFICATE OF DEATH

02322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Talbot ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural St. Michaels				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural / St. Michaels Markham			
c. LENGTH OF STAY IN 1b 5 yrs				d. STREET ADDRESS --- 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle A. Last MARSHALL			4. DATE OF DEATH Month Feb. Day 5, Year 19 59				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1867		9. AGE (In years last birthday) 91 yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Marshall				14. MOTHER'S MAIDEN NAME Courtenay Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dulaney F. DeButts Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure DUE TO pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atherosclerotic cardiovascular d.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-27 , 19 58 , to 2-5 , 19 59 , that I last saw the deceased alive on 2-5 , 19 59 , and that death occurred at 12:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Guy M. Reeser, Jr. M.D. ADDRESS (Street, city or town, state) St. Michaels, Md. DATE SIGNED 2-6-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial Feb. 8, 1959		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Leeds Cemetery		22d. LOCATION (City, town, or county) (State) Hume, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newham & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 59	
24b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.—Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

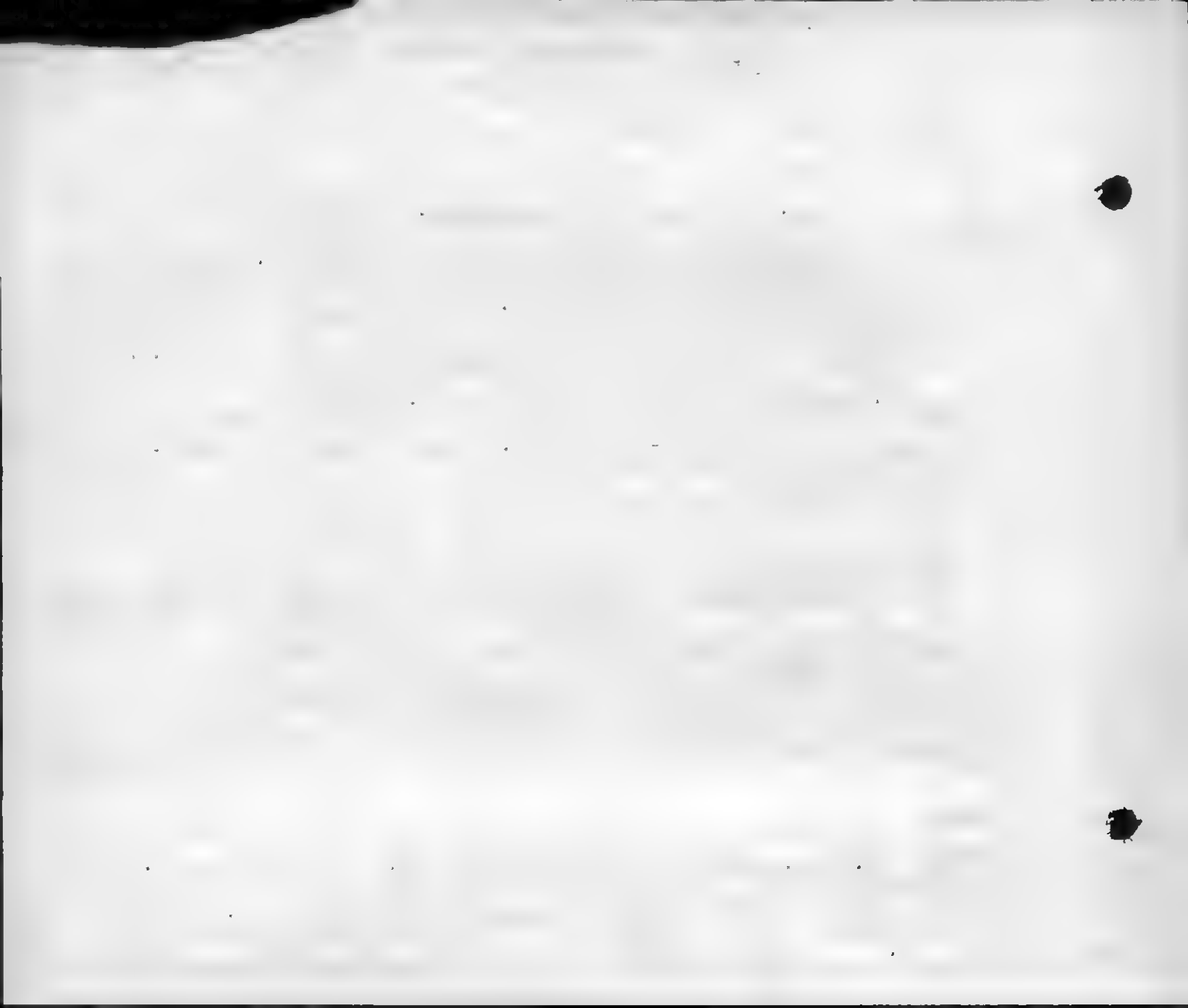
2341

CERTIFICATE OF DEATH

02341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b years x Trappe			
d. NAME OF HOSPITAL (If not in hospital, give street address) Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle ENNIS Last PERCY				4. DATE OF DEATH Month Feb. Day 22 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retail merchant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph B. Percy				14. MOTHER'S MAIDEN NAME Mary V. Hurley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-05-6236		17. INFORMANT Mrs. Blanche Percy		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma - 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 57 , to 2-22 , 19 59 , that I last saw the deceased alive on 2-22 , 19 59 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William L. Winters		M.D. 210 E. Dover		ADDRESS (Street, city or town, state) Easton, Md.		DATE SIGNED 2-23-59	
PHYSICIAN'S NAME (Type) Dr. Wm L. Winters		ADDRESS Dover St.		City or town Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Hillsboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 25 1959	
				24b. REGISTRAR'S SIGNATURE C. E. L. King			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2331

CERTIFICATE OF DEATH

Reg. Dist. No.

02323

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>			
c. LENGTH OF STAY IN 1b <u>11 hrs</u>				d. STREET ADDRESS <u>120 BLOOMINGDALE AVENUE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Almira</u> Middle <u>Rosser</u> Last <u>Poole</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1924</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MR. J. Edwin Rosser</u>				14. MOTHER'S MAIDEN NAME <u>Irene S. Carroll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Mr. Thomas J. Poole (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning, left leg</u>							
345X DUE TO (b) <u>Multiple sclerosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u> </u> 19 <u> </u> to <u> </u> 19 <u> </u> , that I last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city, or town, state) <u>219 S. Washington St. Easton 16, Maryland</u>				DATE SIGNED <u>Feb 11 1959</u>			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				M. D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEBRUARY 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fraughton & Son, Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

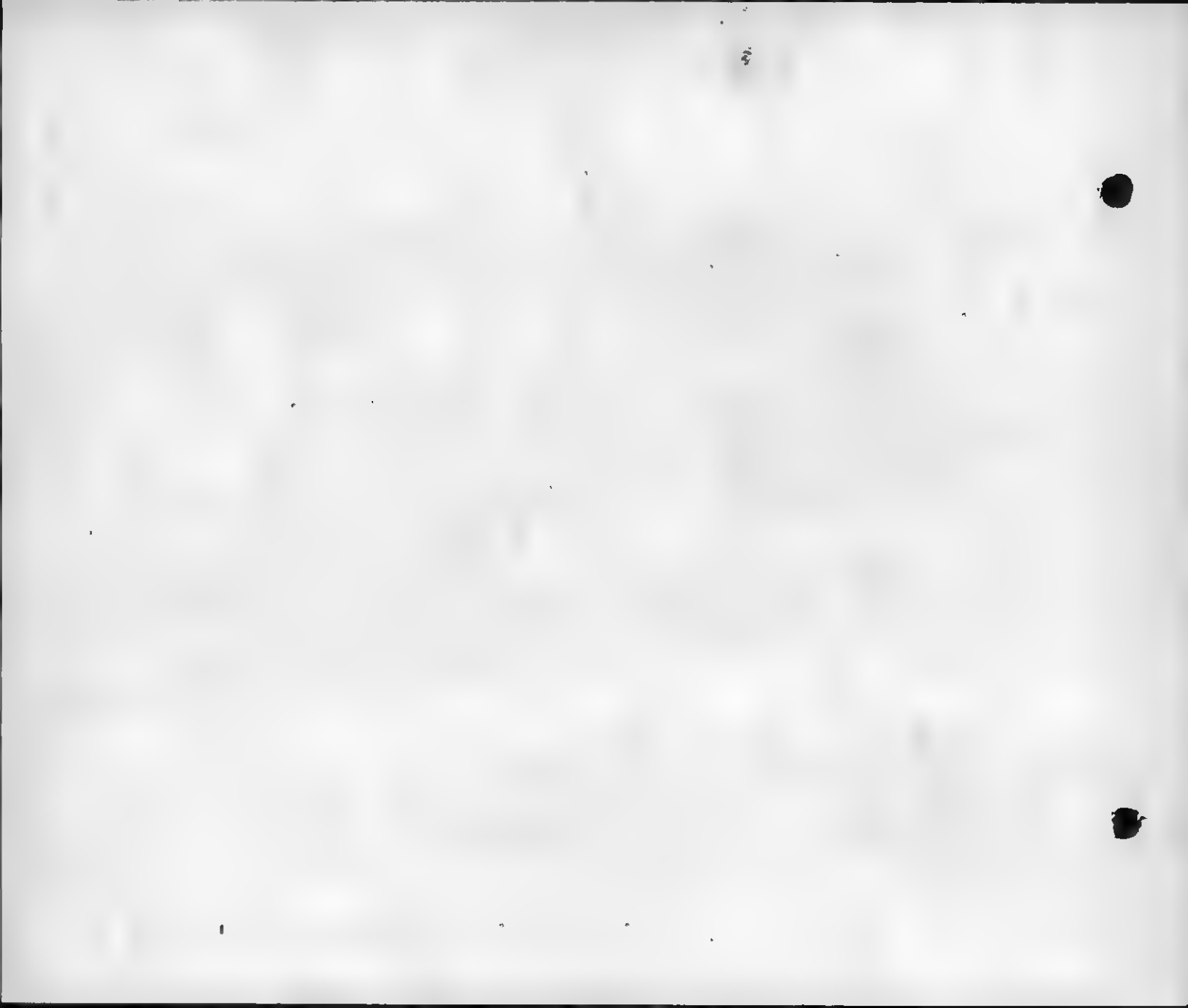
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Queen Anne		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Queen Anne		d. STREET ADDRESS X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth M. Hopkins Rhodes				4. DATE OF DEATH Month Day Year 2/25/59 19			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/78		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hopkins.				14. MOTHER'S MAIDEN NAME Rebecca Cooper.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Thomas Koeneman, Queen Anne			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Arteriosclerotic C-V-D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 11 hrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Lewis M. Welch				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WELCH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY St. Josephs.		22d. LOCATION (City, town, or county) (State) Cordova, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Welch				ADDRESS Chelton Rd		24a. REC'D BY REGISTRAR DATE FEB 25 1959	
				24b. REGISTRAR'S SIGNATURE C. S. Thomas			



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02321

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Easton (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Easton (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN Michael JANGER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5 1959</u>
9. AGE (In years last birthday) <u>22</u>		10. IF UNDER 1 YEAR Months Day Hours Min <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur Janger</u>		14. MOTHER'S MAIDEN NAME <u>Anita L. Howe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Arthur Janger</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Influenza bronchitis</u> <u>501X</u> DUE TO (b) <u>URI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. White</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. L. T. V.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cordova Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>		24a. REC'D BY REGISTRAR <u>MAR 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>		DATE SIGNED <u>2-27-59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2344

CERTIFICATE OF DEATH

Reg. Dist. No.

02327

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Reverol.</u>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>J.</u> Last <u>Scheells</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 5, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James E. Plummer</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Letourneau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Robert T. Schell</u> Address <u>St. Michaels, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>atherosclerotic cardiovascular d.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C.V.D., chronic cardiac failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>St. Michaels, md</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>10-22</u> , 19 <u>54</u> , to <u>2-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-24</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thy M. Reeser Jr.</u>				DATE SIGNED <u>2-6-59</u>			
PHYSICIAN'S NAME (Type) <u>Thy M. Reeser Jr.</u>				M.D. <u>St. Michaels md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin Harrison</u>				ADDRESS <u>St. Michaels, md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2332

CERTIFICATE OF DEATH

Reg. Dist. No.

02320

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>5 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYDEL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) / OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>H.</u> Last <u>SWADA</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1954</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 20, 1893</u>		9. AGE (In years last birthday) yrs <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Swada</u>				14. MOTHER'S MAIDEN NAME <u>Albina Kiwus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ELIZABETH SWADA MARYDEL MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> <u>4x a. i</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a c v d</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Paralysis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 17, 1954</u> , to <u>Feb 22, 1954</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>54</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>St. Mary's, Md. Caroline</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2333

CERTIFICATE OF DEATH

Reg. Dist. No.

02321

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Stevens</u> Last _____				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1882</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Dyer</u>				14. MOTHER'S MAIDEN NAME <u>Ida Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>220-32-0370</u>		17. INFORMANT <u>Mrs. George Sharp</u>		Address <u>Centerville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure -</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction.</u> DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3 Feb.</u> , 19 <u>59</u> , to <u>14 Feb.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Feb.</u> , 19 <u>59</u> , and that death occurred at <u>9:55 P.</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>16 Feb. 59</u>			
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) _____		22b. DATE THEREOF _____		22c. NAME OF CEMETERY OR CREMATORY _____		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thorston Harrison</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE FEB 19 59</u>		24b. REGISTRAR'S SIGNATURE _____	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

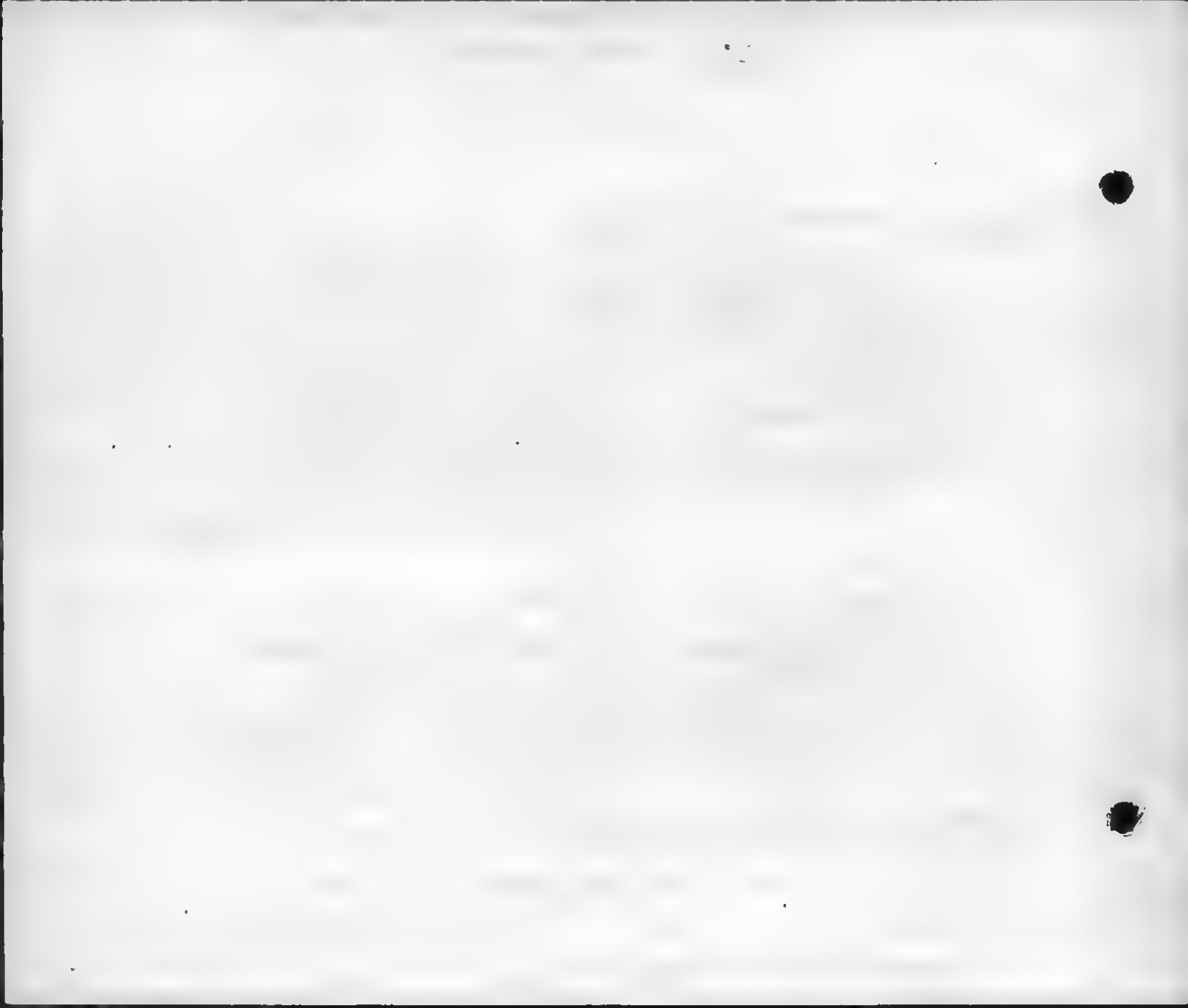
2345

CERTIFICATE OF DEATH

12330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall 14X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vista Nursing Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) O'Quinn First Middle Last Stevens				4. DATE OF DEATH Month 2 Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1863	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Stevens				14. MOTHER'S MAIDEN NAME Emily Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Emily Stevens--Rock Hall, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) atherosclerotic cardio-cerebro vas. d. DUE TO (c) cardiomyopathy cachexia-severe							INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-19-1959, to 2-20-1959, that I last saw the deceased alive on 2-20-1959, and that death occurred at 12:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. St Michaels Md PHYSICIAN'S NAME (Type) 2-21-59							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE FEB 27 '59		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

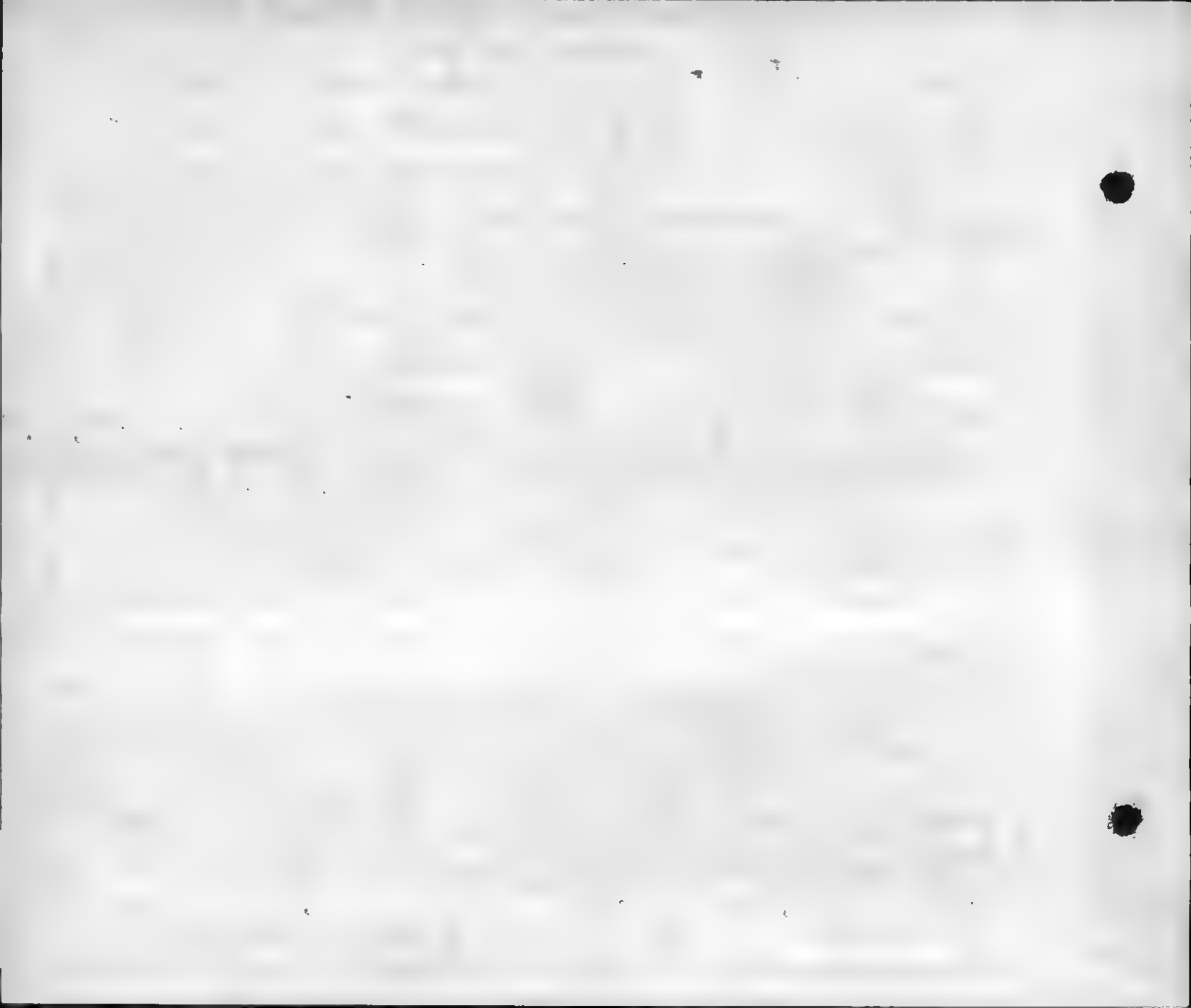
2334

CERTIFICATE OF DEATH

02331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.				d. STREET ADDRESS Denton Road.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last (Mrs) Bernice Evelyn Strauderman				4. DATE OF DEATH Month 2 Day 28 Year 1959			
5. SEX Fe		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 3 1909	
9. AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTH PLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Herman Roddy				14. MOTHER'S MAIDEN NAME Bessie -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO #218-124718		17. INFORMANT Robin Strauderman, son Address 501 Shamrock Lane Pikesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 219 S. Washington St 2612034 DATE SIGNED Easton 16 May 1959							
ACTUAL SIGNATURE E C H Schmidt M.D.							
PHYSICIAN'S NAME (Type) E C H Schmidt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Greenlawn		22d. LOCATION (City, town, or county) (State) Akron, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell-Sims ADDRESS 1900 E. Fort Ave				24a. REGISTRAR'S SIGNATURE John O. Mitchell-Sims DATE MAR 3 1959		24b. REGISTRAR'S SIGNATURE John O. Mitchell-Sims	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLUCK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL				d. STREET ADDRESS FRONT STREET			
3. NAME OF DECEASED (Type or print) First SARAH Middle LYNN Last TAYLOR				4. DATE OF DEATH Month FEBRUARY Day 26 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 28 1958	
9. AGE (In years last birthday) yrs 3		IF UNDER 1 YEAR Months 3 Days 28		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NO DATA				14. MOTHER'S MAIDEN NAME PATRICIA ANN TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MOTHER Address HURLUCK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) neumonia of lung DUE TO Hydrothorax, etc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. C. H. Schmidt				M.D. 219 S. Washington St. Wash 59			
PHYSICIAN'S NAME (Type) E. C. H. Schmidt				Address Easton 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 1, 1959		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR HURLUCK, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton Sr. ADDRESS Federalburg md.				24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02333

Reg. Dist. No.

2336

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before adm is on) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS SES. D. JET ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lawrence Christopher Thomas</u>				4. DATE OF DEATH February 11 1959			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1952</u>		9. AGE (In years last birthday) yrs <u>2</u> Months <u>3</u> Days <u>3</u>	10. IF UNDER 24 HRS Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Lee Thomas, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mother -</u>		Address <u>Easton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-dural hemorrhage</u> <u>IX</u> DUE TO (b) <u>Fracture right parietal bone</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Welty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>LOUIS WELTY</u>		DATE SIGNED <u>2-16-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. D. ...</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	



2346

CERTIFICATE OF DEATH

Reg. Dist. No.

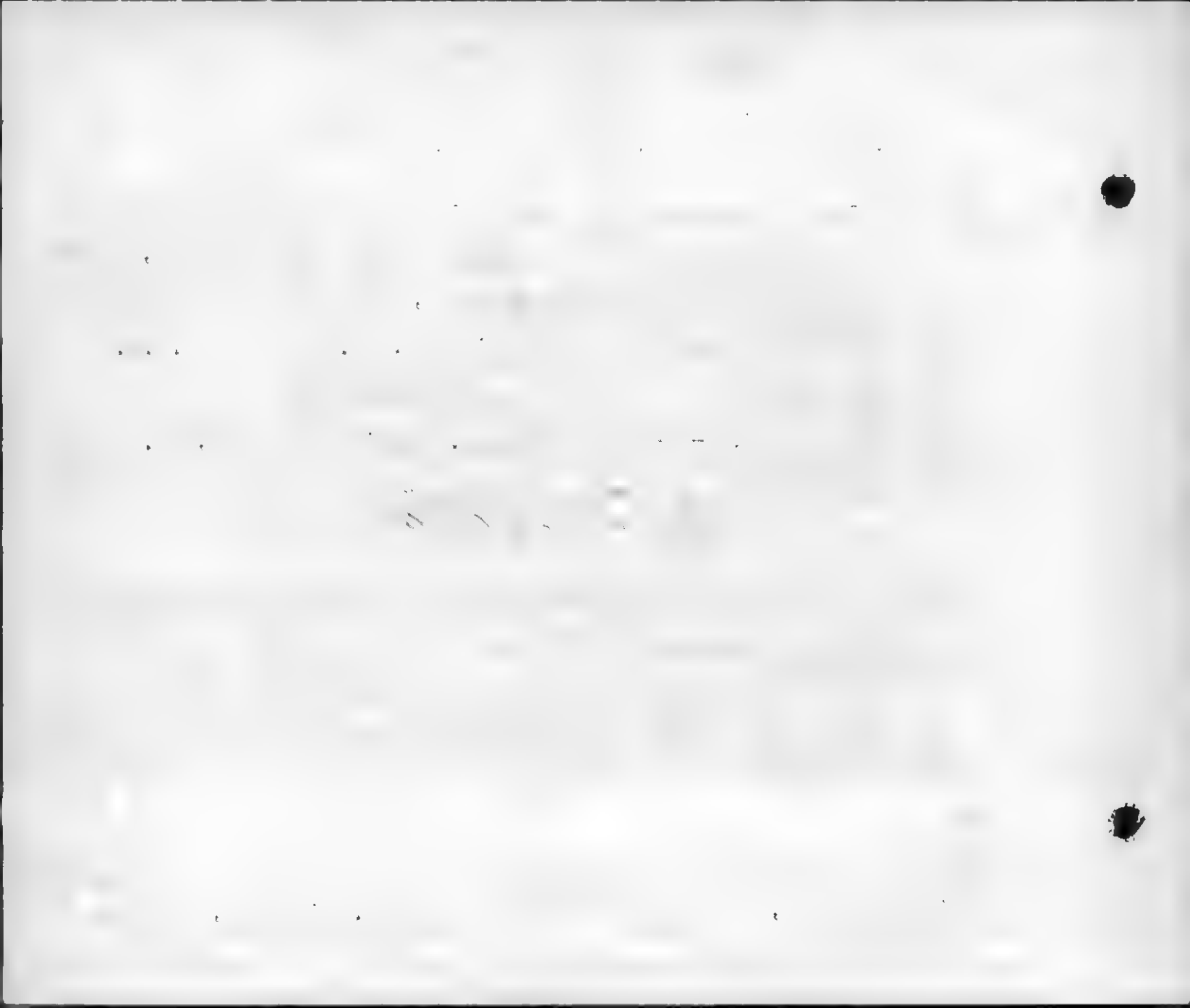
02334

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OGLE THOMAS		4. DATE OF DEATH Month Day Year February 25, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Wittman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Thomas		14. MOTHER'S MAIDEN NAME Hettie Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 219-14-3086	
17. INFORMANT Ernest A. Harrison, Easton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertensive Cerebrovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Refractory Aneurysm		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Feb , 19 59 , to 25 Feb , 19 59 , that I last saw the deceased alive on 25 Feb , 19 59 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.		DATE SIGNED 2-26-59	
ACTUAL SIGNATURE R. Hamilton Harrison M.D.		ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Feb 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	22d. LOCATION (City, town, or county) (State) St. Michaels, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE R. Hamilton Harrison ADDRESS St. Michaels		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2337

CERTIFICATE OF DEATH

Reg. Dist. No

02331

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN 1b <u>8 days</u>				d. STREET ADDRESS <u>R.F.D. #1 Box 292</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Townsend</u> Last <u>Townsend</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1897</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Townsend</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kellum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforated gastric ulcer</u> (b) <u>Shock</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				DATE SIGNED <u>2195 Washington St. 2 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doshield</u>				24a. REC'D BY REGISTRAR <u>F. B. 6 59</u>		24b. REGISTRAR'S SIGNATURE <u>James B. Doshield</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2347
CERTIFICATE OF DEATH

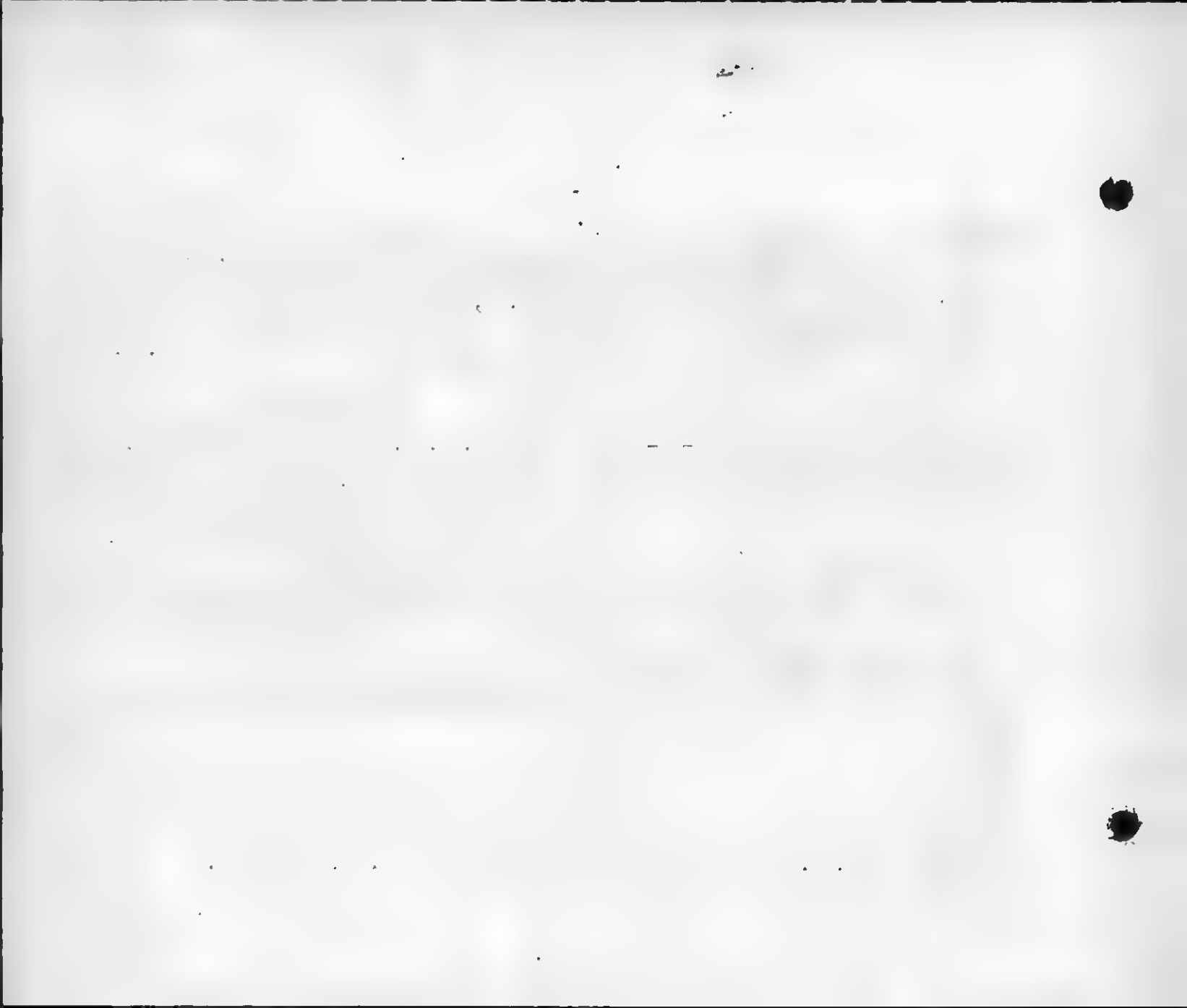
Reg. Dist. No.

02330

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ELLIS Last WHITE		4. DATE OF DEATH Month Feb. Day 6, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1895
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) yard superintendent	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Walter White	
14. MOTHER'S MAIDEN NAME Dollie Jamison		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-03-8229		17. INFORMANT Mrs. G. E. White Address Neavitt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Chromy Cerebr, Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 1/2
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 Feb 19 59 to 6 Feb 19 59 , that I last saw the deceased alive on 6 Feb 19 59 , and that death occurred on 6 Feb 19 59 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Lane Wroth M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Box 487, St. Michaels Md 2-4-59	
PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth		St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	22d. LOCATION (City, town, or county) (State) Elkridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DATE FEB 10 '59
		24b. REGISTRAR'S SIGNATURE Carlton E. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2348

CERTIFICATE OF DEATH

Reg. Dist. No.

02337

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. LENGTH OF STAY IN 1b 5 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home				e. STREET ADDRESS 124 East 6th St.			
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA ESTELLE WILLIAMS				4. DATE OF DEATH Month Day Year Feb. 9, 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wm M. Anderson				14. MOTHER'S MAIDEN NAME Alice Bickford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address Mrs. Grace Doss St. Michaels, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cockeria - severe - generalized 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinomatosis - generalized - metastatic DUE TO (c) adenocarcinoma colon							INTERVAL BETWEEN ONSET AND DEATH - 2 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-25 , 1958 , to 2-9 , 1959 , that I last saw the deceased alive on 2-9 , 1959 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels, Md. DATE SIGNED 2-10-59 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Riverside Memorial Park		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

2338

CERTIFICATE OF DEATH

Reg. Dist. No.

02338

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>RT. #2 Box 10</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>HARRISON</u> Last <u>Willson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 11, 1895</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Annie Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>J. Bailett Tucker</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Arteriosclerotic coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3 p.m.</u> 19 <u>59</u> , to <u>10 p.m.</u> 19 <u>59</u> , that I last saw the deceased alive on <u>9 Feb</u> 19 <u>59</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		ADDRESS (Street, city or town, state) <u>Easton Maryland</u> DATE SIGNED <u>10 Feb 59</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 17, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Tucker</u>		24a. REC'D BY REGISTRAR <u>Easton Md</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>

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